PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

ROOM ---- STATUS S

NAME: Oswald, Lee Harvey

ECR
UNIT # 25260

DATE: 11/24/63 Surg. AGE 24 Yr. RACE W/M

PRE-OPERATIVE DIAGNOSIS: upper GSW of/abdomen and chest with massive bleeding

POST-OPERATIVE DIAGNOSIS: Major vascular injury in abdomen and chest

OPERATION: Exploratory laparotomy, thoracotomy, efforts to repair aorta — BEGAN 1142 — ENDED 1207

ANESTHETIC: General — BEGAN: 1142 — ANESTHESIOLOGIST: 1'15" Dr. M.T. Jenkins, Dr. Gene Akin, Dr. Curtis Epler

SURGEON: Dr. Tom Shires — DRAINS

ASSISTANTS: Dr. Perry, Dr. McClelland, Dr. Ron Jones — APPLIANCES

SCRUB NURSE: Schrader-Lunsford — CIRC. NURSE: Schrader-Bell-Burkett-Simpson — CASTS/SPLINTS

2 counted sponges missing when body closed. Square pack count correct.

SPONGE COUNTS: 1ST _____ 2ND _____

COMPLICATIONS

CONDITION OF PATIENT: Expired at 1207

DRUGS: Ca chloride - 3 vials; Cardiamid - 12; One molar lactate-6; Isuprel - 24; Adrenalin 1:1000 - 3

I.V. FLUIDS AND BLOOD: 3-1000 cc. lactated Ringer's solution; 16- 500 cc. whole blood; 6-1000 cc. 5% dextrose in lactated Ringer's solution

Measured blood loss - 8,376 cc.

Clinical Evaluation: Previous inspection had revealed an entrance wound over the left lower lateral chest cage, and an exit was identified by subcutaneous palpation of the bullet over the right lower lateral chest cage. At the time he was seen preoperatively he was without blood pressure, heart beat was heard infrequently at 130 beats per minute, and preoperatively had endotracheal tube placed and was receiving oxygen by anesthesia at the time he was moved to the operating room.

Description of Operation: Under endotracheal oxygen anesthesia, a long mid-line abdominal incision was made. Bleeders were not apparent and none were clamped or tied. Upon opening the peritoneal cavity, approximately 2 to 3 liters of blood, both liquid and in clots, were encountered. These were removed. The bullet pathway was then identified as having shattered the upper medial surface of the spleen, then entered the retroperitoneal area where there was a large retroperitoneal hematoma in the area of the pancreas. Following this, bleeding was seen to be coming from the right side, and upon inspection there was seen to be an exit to the right through the inferior vena cava, thence through the superior pole of the right kidney, the lower portion of the right lobe of the liver, and into the right lateral body wall. First the right kidney, which was bleeding, was identified, dissected free, retracted immediately, and the inferior vena cava hole was clamped with a partial occlusion clamp of the Satinsky type. Following this immobilization, packing controlled the bleeding from the right kidney. Attention was then turned to the left, as bleeding was massive from the left side. The inspection of the retroperitoneal area revealed a huge hematoma in the mid-line. The spleen was then mobilized, as was the left colon, and the retroperitoneal approach was made to the mid-line structures. The pancreas was seen to be shattered in its mid portion, bleeding was seen to be coming from the aorta. This was dissected free. Bleeding was controlled with finger pressure by

Dr. Malcolm O. Perry. Upon identification of this injury, the superior mesenteric artery had been sheared off of the aorta, there was back bleeding from the superior mesenteric artery. This was cross-clamped with a small, curved DeBakey clamp. The aorta was then occluded with a straight DeBakey clamp above and a Potts clamp below. At this point all major bleeding was controlled, blood pressure was reported to be in the neighborhood of 100 systolic. Shortly thereafter, however, the pulse rate, which had been in the 80 to 90 range, was found to be 40 and a few seconds later found to be zero. No pulse was felt in the aorta at this time. Consequently the left chest was opened through an intercostal incision in approximately the fourth intercostal space. A Finochietto retractor was inserted, the heart was seen to be flabby and not beating at all. There was no hemopericardium. There was a hole in the diaphragm but no hemothorax. A left closed chest tube had been introduced in the Emergency Room prior to surgery, so that there was no significant pneumothorax on the left side. The pericardium was opened, cardiac massage was started, and a pulse was obtainable with massage. The heart was flabby, consequently calcium chloride followed by epinephrine-Xylocaine® were injected into the left ventricle without success. However, the standstill was converted to fibrillation. Following this, defibrillation was done, using 240, 360, 500, and 750 volts and finally successful defibrillation was accomplished. However, no effective heart beat could be instituted. A pacemaker was then inserted into the wall of the right ventricle and grounded on skin, and pacemaking was started. A very feeble, small, localized muscular response was obtained with the pacemaker but still no effective beat. At this time we were informed by Dr. Jenkins that there were no signs of life in that the pupils were fixed and dilated, there was no retinal blood flow, no respiratory effort, and no effective pulse could be maintained even with cardiac massage. The patient was pronounced dead at 1:07 P.M. Anesthesia consisted entirely of oxygen. No anesthetic agents as such were administered. The patient was never conscious from the time of his arrival in the Emergency Room until his death at 1:07 P.M. The subcutaneous bullet was extracted from the right side during the attempts at defibrillation, which were rotated among the surgeons. The cardiac massage and defibrillation attempts were carried out by Dr. Robert N. McClelland, Dr. Malcolm O. Perry, Dr. Ronald Jones. Assistance was obtained from the cardiologist, Dr. Fouad Bashour.

/s/
Tom Shires, M.D.